



CANNON BUILDING
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STATE OF DELAWARE
BOARD OF PHARMACY

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COLLEGE PRACTICAL EXPERIENCE FORM

INSTRUCTIONS

This form is for applicants for Delaware Pharmacist licensure who completed internship hours while in a school or college of Pharmacy.

- The applicant completes the APPLICANT INFORMATION section and sends this form to his or her school or college of pharmacy.
- An official of the college or school completes the information in the VERIFICATION section, signs and seals the form and mails it directly to the Board office at the address above.

APPLICANT INFORMATION

Name of Applicant: _____ Application ID: _____

VERIFICATION

1. Name of School or College of Pharmacy: _____
2. Is/was the applicant named above a full-time student at this school or college of Pharmacy? Yes No
3. Has the applicant successfully participated in the school's Practical Experience Program? Yes No
4. Enter the number of hours of practical experience that the applicant obtained **during or after the first professional year** of the Pharmacy curriculum.
Total Hours: _____ From (month/day/year): _____ To (month/day/year): _____
5. Enter the minimum number of hours of experience that the **current** structure of the Practical Experience Program at this institution requires:
Community Pharmacy Practice: _____ hours
Hospital Pharmacy Practice: _____ hours
Clinical Pharmacy Services: _____ hours

"Clinical Pharmacy Services" include medical rounding, patient chart review, drug therapy assessment, patient interview and education.

SCHOOL OFFICIAL CERTIFICATION

I certify that the above information is accurate.

School Official Printed Name: _____ Title: _____

Signature Of School Official: _____ Date: _____

AFFIX
INSTITUTION
SEAL

Mail this form *directly* to the Board of Pharmacy office at the address above.